THE TREATMENT OF DISSOCIATIVE DISORDER PATIENTS: AN OVERVIEW OF DISCOVERIES, SUCCESSES, AND FAILURES

Richard P. Kluft, M.D.

Richard P. Kluft, M.D., is Director of the Dissociative Disorders Program at The Institute of Pennsylvania Hospital, and Clinical Professor of Psychiatry at Temple University School of Medicine, both in Philadelphia, PA.

For reprints write Richard P. Kluft, M.D., The Institute of Pennsylvania Hospital, 111 North 49th Street, Philadelphia, PA 19139.

ABSTRACT

The treatment of dissociative disorder (DD) patients with multiple personality disorder (MPD) and allied forms of dissociative disorder not otherwise specified (DDNOS) has advanced rapidly over the last two decades. It is clear that many patients with these conditions can be treated successfully, and several schematizations of the treatment process have been published. However, all studies to date have been open; controlled studies remain to be done. This presentation will review what is known about the treatment of these conditions, however flawed the state of our knowledge, as judged by the criterion of being associated with good clinical results. A number of relevant issues will be discussed.

INTRODUCTION

It is my task to share the perspective of an experienced clinician who has had considerable success in the treatment of dissociative disorder (DD) patients. I will try to communicate my understanding of the current state of knowledge about what works and what fails to work in the treatment of these patients. That is, I will discuss, "What to do until the controlled studies come." Everything that I share will represent the best I know as of the date of my last revision of this manuscript. However, everything I say will fall short of the criteria for demonstrating efficacy that Putnam held out for the field in his 1986 paper, and in his Amsterdam presentation (1992) as well. I am reminded of an old medical school jest, in which my father remembered a professor telling on the first day of classes: "Gentlemen, half of what we teach you in your four years here will be true, and half will ultimately prove false. Unfortunately we do not know which half is which." I will aspire to an accuracy level above that of random chance, but only time will tell if I have achieved it.

Most dissociative disorder patients under long-term treatment today, apart from those with depersonalization disorder, have at least the rudimentary structure of multiple personality disorder (MPD). This is the case even if their overt phenomenology is more consistent with a diagnosis of dissociative disorder not otherwise specified (DDNOS) and might be described by many as "ego state disorders," consistent with the terminology introduced by the Watkins (1979). Longitudinal studies of MPD patients indicate that most of them spend a considerable percentage of their lives with manifest phenomenology consistent with a DDNOS diagnosis (Kluft, 1985, 1991a), and longitudinal studies of DDNOS patients demonstrate that they often prove to merit an MPD diagnosis on follow-up reassessment (Boon & Draijer, 1993; Kluft, 1985, 1991a). Therefore, in the interests of simplicity I will refer to all such patients as MPD for the remainder of this communication.

HISTORICAL BACKGROUND

It often is useful to look backward before dwelling on the present in order to contextualize what is contemporary and pay appropriate homage to those giants of the past. As an editor, I am all too aware that many of the fine manuscripts I review owe their quality to the contributions of others who are not being credited for their work by younger authors who only know of the original sources from the reference lists of the articles they have read, and have forgotten that all knowledge begins somewhere, with someone. I regret that the limitations of space preclude all but a cursory tribute to a handful of selected individuals.

Over 90% of studied cultures and societies have conditions in which another entity is understood to have taken control of the body of the afflicted individual (Foulkes, personal communication, October, 1984). Despite the infinite variety of the possession states, their common features are that, "An individual suddenly seems to lose his identity to become another person. His physiognomy changes and shows a striking resemblance to the individual of whom he is, supposedly, the incarnation. With an altered voice, he pronounces works corresponding to the personality of the new individual" (Ellenberger, 1970, p. 13).

Until the end of the eighteenth century, many individuals in Western Society demonstrated these phenomena. They were understood, within the explanatory paradigms of their eras, to be afflicted with the various Judeo-Christian forms of possession, and were approached therapeutically with the culturally-sanctioned Judeo-Christian rituals of exorcism.

The emergence of what Ellenberger has termed "the

87

first dynamic psychiatry" and the non-theological explanation of mental illness can be traced to many cultural and political changes in Europe. However, they were crystallized in the November, 1775 confrontation of the celebrated exorcist, Father Johann Joseph Gassner, with the more "scientific" physician, Franz Anton Mesmer, M.D. Mesmer's theories of "animal magnetism," however erroneous, informed a novel theory and practice of therapy that prefigured contemporary hypnosis. Mesmer demonstrated that he could both induce and dispel the types of symptoms that Gassner had been treating with exorcism, and concluded that Gassner had achieved his successes not by the casting out of demons, but by the unwitting use of his animal magnetism. Notwithstanding, Mesmer was later discredited by a French Royal Commission. Ironically, it was argued that Mesmer, unwittingly, had cured his patients not by animal magnetism, but by suggestion. The events of 1775 played an important role in undermining the theological explanation of mental disease. This abbreviated account is indebted to Ellenberger's classic, *The Discovery of the Unconscious* (1970).

With a change in the dominant paradigms for understanding (and expressing) mental illness, the possession states did not abruptly cease to exist. Instead, what we now call MPD and DDNOS began to be described in the literature without a supernatural explanation. Viewed from this perspective, these conditions are no more than the secular expression of the same psychological structures that were found in the Judeo-Christian possession syndromes. MPD is the contemporary and demystified form of an anthropological commonplace. In societies in which indigenous possession states remain common, the psychopathological niche that MPD occupies in American and Western European populations is already filled, and MPD will remain uncommon (for a study consistent with this hypothesis, see Adityanhjee, Raju, and Khandelwal (1989).

Within years of this paradigm shift, Petetain described patients which we would diagnose with MPD, and just after 1800, Benjamin Rush, a noted patriot and the founder of American Psychiatry, noted such patients at the Pennsylvania Hospital . However, the first attempt to delineate a specific syndrome or disorder consisting of these phenomena was made by Eberhardt Gmelin in 1791when he reported a case of *umgetauschte Personlichkeit*, or exchanged personality (Crabtree, 1993; Ellenberger, 1970; Greaves, 1993).

Over the course of the nineteenth century, numerous authorities made many noteworthy contributions to the description of MPD phenomenology, but all too many cases were observed and studied rather than treated. Onno van der Hart has spearheaded an effort to restore recognition of Pierre Janet and his innumerable therapeutic contributions; his work is a valuable tribute to Janet as well as a resource for the study of Janet's techniques (e.g., van der Hart, Brown, & van der Kolk, 1989; van der Hart, Brown, & Turco, 1990; van der Hart & Brown, 1992; van der Hart & Friedman, 1989, etc.).

Among the unrecognized pioneers, I hold in high esteem a man whom I consider my teacher and mentor. Antoine Despine, M.D., a French general practitioner of high repute and a student of magnetism (hypnosis), appears to be the first to have effected a non-exorcistic cure of MPD, in his treatment of "Estelle." Although the original source (Despine, 1840) is difficult to locate, Ellenberger (1970) has described his therapeutics, I have summarized aspects of his work (1984a, 1986) and Fine (1989) has done an exegesis of his text that demonstrates his awareness of ideas and concerns that we might have thought to be more modern insights.

Despine was referred a young woman of eleven whose manifold symptoms had defied the efforts of many physicians. After Despine exhausted his armamentarium of minerals, various baths, and massages, he learned from her mother that Estelle was being serenaded and comforted by choirs of angels and heard inner voices. He began to suspect a magnetic (i.e., hypnotic) psychopathology. He gradually gained access to a number of alter states (but conservatively only mentioned a few in his text, leaving the remainder of his observations in a fascinating appendix). He learned how to reach them both with hypnosis and by simple request. He learned how to relate to a variety of personalities. He learned how to bring about their reconciliation by addressing their issues and their relationships with one another. Further, using imagery suggested by the patient, he facilitated their joining with hypnosis. Interestingly, Estelle stayed integrated until her death.

Despine was indeed my teacher. When I first encountered MPD phenomena in 1970 and tried to get some advice on treating them, most of those to whom I turned said that I must have been duped or that I had caused them by some error. I was assured that if I did not reinforce them, they would go away. When this advice failed to benefit the patients, I looked for help elsewhere. I felt confused by Thigpen and Cleckley's work with "Eve" (1954, 1957) because much of what they said was inconsistent with my own experience, a misgiving validated when it proved that Eve had not been treated successfully (Sizemore & Pittillo, 1977). I studied the landmark article by Bowers and her colleagues (1971), but I was too inexperienced to appreciate its wisdom, which encompassed basic principles but did not tell me what to do, and too shy to call one of the co-authors. This was prior to the publication of *Sybil* (Schreiber, 1973), which described the work of Cornelia B. Wilbur, M.D. In any case, after its publication I was told by a prestigious professor that *Sybil* was a fraud, and did not read the book until I had been working with MPD for six years. It was before Ralph Allison (1974) published his methods, and I did not run across his article until a year or so after its publication.

Therefore, I read about Despine, over and over, in Ellenberger (1970), and was able to read a part of his original work. I read some Janet. Melding this with my psychoanalytic orientation, I conceived of approaching MPD by treating at once the whole person and the alters, by working both across personalities and with personalities individually, and by using circumspect hypnotic interventions in order to address dissociative phenomena that did not appear to yield easily to alternative methods. I became both a psychoanalytic candidate and a student of hypnosis. What I learned from Despine led me to achieve very good clinical results with MPD patients

before I had the opportunity to meet the twentieth century pioneers in the treatment of MPD, such as Wilbur, Caul, Bowers, Newton, and Allison.

CURRENT SCHEMATA FOR THE TREATMENT OF MPD

At present a wealth of information is available concerning the treatment of MPD. It is generally accepted that a supportive-expressive psychodynamic psychotherapy, facilitated when necessary with hypnosis, employing the adjuctive use of medication, availing itself on occasion of certain techniques borrowed from cognitive and behavioral therapy, and supported when possible with ancillary creative arts therapies, is an appropriate approach for most MPD patients (Wilbur & Kluft, 1989). Putnam's 1989 text, *The Diagnosis and Treatment of Multiple Personality Disorder,* has a well-deserved reputation as the most widely respected single book on the treatment of MPD. It has the capacity to speak to the needs of the rank beginner and the advanced clinician as well. Many important articles on treatment are found in two special MPD issues of *Psychiatric Clinics of North America* (March, 1984 and September, 1991) edited by Bennett G. Braun, M.D., and Richard J. Loewenstein, M.D., respectively. Braun's 1986 *Treatment of Multiple Personality Disorder,* has much solid information to offer. *Clinical Perspectives on Multiple Personality Disorder,* by Kluft and Fine (1993), has many pragmatic articles for the clinician, and offers a chance to observe the process of several psychotherapies done by experts. Ross (1989) and Bliss (1986) have written useful books, but are too unique in their perspectives to be useful as introductory texts for the field. Most of the hypnotic interventions now used for work with MPD were published in the *American Journal of Clinical Hypnosis* between 1982 and the present.

There is general consensus that the treatment of MPD has the form of a posttraumatic therapy as understood by Herman (1992), and that its many steps or stages conform to the three stage model Herman has described and acknowledged was first proposed by Janet. Herman's stage 1 involves the establishment of safety. Stage 2 involves remembrance (of traumata) and mourning. Then, stage 3 is focused on reconnection. In another contribution in this issue (Kluft, 1993a), I have compared the models of MPD therapy described by Braun (1986), Kluft (1991b), and Putnam (1989). In essence, they all follow the sequence Herman outlined. For example, I (1991b) have noted nine stages: 1) Establishing the Therapy; 2) Preliminary Interventions; 3) History Gathering and Mapping; 4) Metabolism of Trauma; Moving Toward Integration/Resolution; 6) Integratión/Resolution; Learning New Coping Skills; 8) Solidification of Gains and Working Through; 9) Follow-up. Of these, stages 1-3 are designed to maximize safety and communication, stage 4 involves intense work with traumatic material, and stages 5-9 involve reconnection, both within the alter system and interpersonally.

It has become clear that the effective treatment of MPD cannot begin with extensive work on traumatic materials. This almost always leads to decompensation. Although the patient may come for treatment because of the emergence of such material, and some initial work with it may be necessary, it is important to move the patient into what Fine (1991) has called a phase of suppression in order to restabilize the patient. Although many MPD patients appear to be intellectually gifted and to have high ego strength, it does not follow that one can proceed to address their traumatic experiences in short order. Their vulnerabilities almost invariably overwhelm and invalidate their strengths, an event that can prove demoralizing to patient and therapist alike. Fine (1991, 1993) and Kluft (1993a, 1993b) have addressed these considerations and suggested therapeutic approaches that take them into account. van der hart and Brown (1992) and van der Hart, Boon, Steele, and Brown (1993) discuss these concerns specifically in terms of abreaction and work with traumatic memories.

I will offer a description of central concerns in the treatment of MPD viewed through the lens of Herman's (1992) three phase model. In the first, or safety phase, there must be a prioritization on creating an atmosphere of safety in the therapy, and an anticipation of what will be necessary to make the next phase safe as well. Consequently the treatment is governed by what I call Belafonte's law: "House built on a weak foundation, it will fall! Oh, yes! Oh, yes! Oh, yes." A primary concern is accorded to ego-strengthening. The patient is reached by an empathic focus on self-experience, and self-object transferences (Kohut, 1977). The patient is taught many techniques to achieve self-efficacy (Bandura, 1977) in the treatment and in his or her life. The patient's management of shame (Nathanson, 1992) and guilt is addressed. Symptomatic relief is offered. The increasingly strengthened patient, the gradually enhanced therapeutic alliance within the therapeutic dyad, and the better-informed therapist test out the techniques they may use in the management of traumatic material before moving deliberately to encounter and master it. These concerns are addressed in detail elsewhere (Kluft, 1993a).

Stage 2, which Herman (1992) calls remembrance and mourning, involves the mastery and detoxification of the patient's traumatic experiences. Here there are tensions between the need to optimize the patient's independence and autonomy, and the therapist's appreciation that this type of work must be carefully controlled, dosed, and titrated lest it prove disruptive. The transferences are traumatic (Loewenstein, 1993), and one is more impressed with the posttraumatic aspects of MPD than the features of the many alters. It is essential, notwithstanding the vicissitudes of memory, to provide the patient the opportunity to achieve a sense of the continuity of his or her life, even across traumatic events.

In Stage 3, which Herman calls reconnection, there is a press to integrate the self by the joining and blending of the personalities, to integrate with others by resolving interpersonal problems and to treat whatever characterologic problems impede the patient's adjustment with others. Now the patient has what I have called "single personality disorder," and must face the consequences of integration, the task of grappling with "normal problems," and the task of preparing for the future (Kluft, 1988a). Often both the dynamics

89

and the transference assume the configurations of more classic psychoanalytic patterns.

CURRENT STANCES TOWARD THE TREATMENT OF MPD

It is impressive that although the vast majority of the recent literature on the treatment of MPD advocates integration, and series of patients treated to integration have been described and followed up, with the demonstration of excellent stability (Kluft, 1984b, 1986), it is by no means certain whether working toward integration characterizes the majority of MPD treatments in progress throughout the world. In fact, if one interviews a wide variety of therapists who treat MPD, a wide variety of therapeutic stances will be encountered. In 1988(b) I tried to classify what I encountered, in an article entitled "Today's Therapeutic Pluralism," and described seven basic orientations.

Although I have used other descriptors elsewhere, here I will call the first stance *Desperate Eclecticism*. It is common among therapists first encountering MPD and therapists who do not make an effort to learn about MPD. It is best described as a "diffuse conglomeration of theories and practices conceived in desperation and employed in the fervid hope that one will find something that works" (Kluft, 1988b, p.1). When therapists with this orientation give others advice, they usually overgeneralize from a limited data base and emphasize serendipitous or idiosyncratic factors. They often become convinced that whatever they did immediately before an improvement or the resolution of a crisis was the key to the treatment, recurrently making post hoc, propter hoc assumptions. They are very eager to learn new techniques, because their style relies on the trial and error application of many approaches until something appears to work. This stance is acknowledged to exist, but cannot be recommended.

A second stance might be called *The Procrustian Imperative*. In short, to the man whose only tool is a hammer, everything looks like a nail. Some therapists are deeply wedded to and identified with a particular theory and modality of choice. They become determined to treat MPD with their modality of choice, and to understand MPD with their theory of choice. They rationalize their dismissal of all advices and observation that would go contrary to their preferred paradigm. Apparently they are sufficiently threatened that they find learning new ideas intolerable. They offer advices that flow from the basic principles of their preferred models, and minimize or discount the findings and events that are anomalous with respect to their ideas. Such fanaticism is not to be encouraged. I regret that I cannot find a source for a saying I have heard attributed to Charcot, "A theory is a wonderful thing, but it does not prevent other things from existing."

A third stance could be termed *Wishful Minimization*. It proceeds from the premise that MPD is not a genuine clinical phenomenon that must be approached in order to be resolved. Instead it is understood as an iatrogenic artifact, a social psychological response to certain demand characteristics inherent in certain situations, or some form of charade (with the possibility of sincere self-deception by a histrionic, manipulative, gullible, or mythomaniacal patient). The treatment philosophy can be reduced to "leave it alone and it will go away," presumably by non-reinforcement. This point of view is very strong among skeptics, senior academicians with minimal clinical experience with MPD phenomena, and those who have never knowingly encountered MPD and therefore cannot believe that the modern literature on MPD is credible. There is a body of evidence to suggest that it is completely ineffective (Kluft, 1985); therefore, it is contraindicated.

A fourth stance might be called *Personality-Focused*. "Clinicians who work in this manner fall into two large groups: those who do so on the basis of a thoughtful theoretical orientation that does not regard dividedness per se as problematic, and those who appear to accord the personalities a face validity as people and attempt to nurture them into health via some variety of corrective emotional experience"(Kluft, 1988b, p.2). The first group often do therapies that involve a form of a problem-solving inner group therapy or inner family therapy among the many selves. All parts are encouraged to collaborate more smoothly without necessarily moving toward integration. Integration may be pursued if the patient so wishes, but a more harmonious and functional arrangement among the alters is the major objective. Many patients have been helped by this approach. The second group emphasize nurture as a curative element as they try to undo the hurts of the past in a highly tangible manner. Although occasional dramatic successes are reported by such therapists, many unfortunate outcomes are also noted. Consequently, it cannot be recommended. A detailed discussion of some of the issues related to orientations that do not advocate integration is available (Kluft, 1993c).

A fifth stance which has received much interest of late might be called *Adaptationalist*. It describes a group of distinguished experts who see themselves primarily as pragmatists. They may prioritize the management of life activities, the maintenance and improvement of function, and accord integration a secondary goal, which can be approached only if life issues are resolved or stabilized. Some of these therapists often point to the unavailability and/or expense of treatments that move toward integration. There is not doubt that this stance is an inevitable part of almost all MPD therapies at times when the patient is overwhelmed, and is called into play by therapists who prefer other stances but appreciate that in a particular situation or with a particular patient a more ambitious focus would ask too much of the patient's resources. Unfortunately, it is also a favored stance of those who minimize the value of psychotherapy or are motivated to select an approach that makes less demands on an agency or generates lower bills for a third party. More unfortunately still, it is often the stance of therapists who are "burned out" and have little left to give to their work with their patients. This stance offers them a rationale for their inability to commit themselves to an optimal course of treatment. The long-term stabilization or the capacity of patients treated in this manner to terminate treatment in an improved state and maintain that improvement has yet

90

to be demonstrated.

The sixth and seventh stances, *Strategic Integrationalism* and *Tactical Integrationalism*, are those most frequently taught in workshop settings, and are associated with the vast majority of successful treatments. Although there are some basic theoretical and technical differences in these approaches, they rarely can be distinguished completely from one another. The vicissitudes of clinical practice often force a strategic integrationalist to use approaches more central to tactical integrationalism, and vice versa. Therefore, the theoretical differences are more pronounced than the technical ones, and one might have to witness a number of hours of a number of MPD therapies in order to determine which orientation a given therapist implicitly followed.

Strategic integrationalism "focuses on rendering the dissociative defenses and structures that sustain MPD less viable, so that the condition in essence collapses from within. Its ideal goal is the integration of the personality in the course of the overall resolution of the patient's symptoms and difficulties in living" (Kluft, 1988b, p.2). Consistent with the psychoanalytic tradition of the analysis and resolution of pathological defensive structures, particular techniques and interventions are valued less for themselves than for the long-term goals to which they contribute. Hypnotic, cognitive-behavioral, and other techniques may be used sparsely or liberally. It is interesting that with experience, success, and increasing equanimity with MPD treatment, more therapists move toward this stance, which was exemplified by the late Cornelia B. Wilbur, M.D., and melded with hypnotic and cognitive approaches in the service of strategic goals by Kluft.

Tactical integrationalism espouses the same ideal goal as Strategic Integrationalism, but the actual conduct of the therapy reveals a predominant concentration on tactics, and on discrete interventions that serve as adroit devices to accomplish a series of objectives. Such therapies are often quite eclectic and ingenious. Their planfulness and deliberateness may be conspicuous. At times these therapies take the form of a series of short-term therapies within the context of a long-term therapy. The ancestry of this approach to MPD is the eclectic hypnotic approaches used by many pioneers, exemplified by Allison, Braun, and the late David Caul, M.D., more recently modified by the cognitive-behavioral contributions of Fine (e.g., 1991, 1993), who has raised its exposition to a new level of sophistication. Because more training programs at this point in time are cognitive-behavioral, eclectic, and/or minimally supportive of the long-term psychodynamic treatments, it seems likely that increasing numbers of young practitioners will find this model most congenial.

It will be interesting to track the fates of these stances over time. It is possible that trends in the education of psychiatrists and psychologists rather than prior demonstrations of efficacy may determine which become most popular. At this moment in time, it is important for the clinician to appreciate that these stances are more useful as heuristics and general principles than as a guide to the vicissitudes of daily practice. Because the circumstances and stability of an MPD patient may vary considerably, and because some aspects of the treatment may require interventions otherwise absent from the therapy, a therapy that is purely based on one stance from beginning to end is a rarity. A therapist needs the flexibility to work with the model that best suits the immediate situation, even if it differs from the one that governs the overall strategy. For example a skillful strategic integrationalist therapy may begin with an adaptational stance or a personality-focused approach in order to stabilize the patient's life and/or build rapport. The patient might be approached with techniques most characteristic of tactical integrationalism in order to build ego strength and prepare the patient for work on traumata. With momentum and an increased therapeutic alliance a more classic strategic integrationalist stance may then come to dominate the therapy, except for occasions when the application of specific techniques proves necessary to reach otherwise inaccessible material.

It is the opinion of many experienced therapists that when treatment must be given with less than optimal intensity, adopting a tactical integrationalist stance, from which one is prepared to move toward adaptational and personality-focused stances when the patient may be unable to move forward for the moment, is a prudent decision.

CURRENTLY ACCEPTABLE APPROXIMATIONS TO CLINICAL WISDOM

I have chose this rather oblique and apologetic title because in the interests of expressing a large number of ideas and observations rather rapidly I will inevitably appear to be more sure of myself on the printed page than I am in the privacy of my own mind. I want to emphasize once again that much of the best we know is quite flawed, tentative, and subject to reconsideration in the face of further experience and information. Since much of the work I will refer to is my own, perhaps the following information about me will help the reader to contextualize these remarks.

I have been working with dissociative disorder patients (knowingly) since December 1970. I have seen well over a thousand patients with DDs in consultation, and have taken over 200 into treatment for at least three months. Of these, 150 have achieved stable integration by research criteria (Kluft, 1986). Approximately 10% of my patients have interrupted their treatment, for a wide variety of reasons. Of the remainder, about 10% have ended treatment without a mutually satisfactory result (integration, symptomatic relief, and relatively unobstructed pursuit of life goals). The remainder integrated and left intense treatment or are still in therapy. Of those who reached stable integration, at last systematic follow-up virtually all were doing reasonably well in life, and still integrated. When I started doing follow-up research I saw the full spectrum of MPD psychopatholgy; currently I tend to be working with populations at the extremes of high ego strength and cooperation on the one hand and the most refractory and difficult patients with one or more prior treatment failures on the other. I do not enter patients whom I treat for other therapists in my dissociative disorders pro-

gram into my statistics unless they later become my patients, because they often come from different states or countries, and I have no way of following them in a standardized manner.

The Natural History of MPD Project

From 1972 through 1990 I followed a series that ultimately included approximately 250 MPD patients over time, and published a study on this work involving 210 patients in 1985, entitled "The Natural History of Multiple Personality Disorder." When I started finding cases of MPD I was working in a community hospital as well as a specialized psychiatric facility. In that community hospital, it was customary that if a physician's name was on a patient's chart, even as a prior consultant, upon the hospital admission or the emergency ward visit of the patient, the physician would be informed. The medical ethos dictated that continuity of care was to be preserved, and also that no one would take over care of another doctor's patient unless this had been agreed upon or insisted upon. Perhaps this was wasteful financially, but we all got to know our patients well, and often knew their families.

Over eighteen years I was able to follow MPD patients I had diagnosed in the community. I was not restricted to following those I knew and treated. I also could follow those I had seen in consultation or for inpatient treatment and returned to another therapist or to their family doctor or minister. I saw those that had no mental health treatment; those who were treated by therapists who thought my diagnosis was crazy (and usually said so!); and those treated by professionals who accepted the diagnosis, but did not or would not address the MPD, and tried to either treat around the MPD or to treat it as if it were another more familiar disorder. I could see what happened to all cohorts over time. In assessing the patients I originally used my clinical ingenuity, and then a semi-structured interview called the CSDS (Center for the Study of Dissociative States) Protocol. It remains unpublished, but was distributed widely, and many of its items made their way into the SCID-D (Steinberg, 1993).

In a typical scenario, a patient who had been assigned to me for psychiatric hospitalization in 1975 and returned at discharge to a community mental health center for treatment with a therapist who did not address the MPD might be hospitalized for the consequences of an automobile accident in 1983. I would be informed, and if I were not consulted, I nonetheless would get permission to visit and interview the patient. In this manner I got second, third, fourth, and more opportunities to reassess persons who at one time had unequivocally qualified for the diagnosis of MPD. The range of follow-up for the 1985 study was 3-13 years.

What I found is that of all the patients who had had MPD on assessment and had received no psychiatric treatment whatsoever in the meanwhile continued to demonstrate MPD or DDNOS with the features of MPD on follow-up. Although it is possible to argue that I induced an iatrogenic artifact or compelling demand characteristics initially and they persisted, or that I did so twice or more as I reassessed the patients, their interval histories indicated that they were living with a DD adaptation before the first assessment and in the interval between the assessment. Therefore, while these criticisms may be leveled at the phenomenology I elicited, they do not address the given history, often buttressed by family members. I tended to visit these patients during evening visiting hours to maximize the likelihood of getting corroboration. The presence or absence of the phenomena of MPD was my main concern. I did not focus on particular details, which I appreciated might change over time, and were subject to many possible contaminants. Although I observed the types and levels of dissociative symptomatology varied and fluctuated, I discovered that the natural remission rate of MPD which is not reinforced by specific MPD psychotherapies is nil. Hence minimalizing approaches may diminish an MPD patient's demonstration of overt MPD phenomena, but they are unlikely to make the condition improve in any lasting sense.

What of the patients in treatment with therapists who totally discounted the MPD diagnosis? On repeated reexamination, all retained their MPD. Many, when I asked how they conducted themselves with their therapists, described concealing the MPD because the therapist appeared so unaccepting of it. Therefore, therapy that denies the MPD does not lead to its remission.

When a patient with MPD is in treatment with a therapist who does his or her best, acknowledges the MPD, but does not address the MPD specifically (in this series it was usually because the therapist did not know how to treat MPD), most patients retain their MPD. One patient nonetheless found a way to get well by bringing in all the alters with their issues while each alter passed for the host in its sessions. A second may have spontaneously integrated in a compassionate but non-specific therapy. The patient believed that this had happened, and even with aggressive hypnotic efforts I could not elicit alters in a follow-up several years later. In this series, then, perhaps 3% of MPD patients integrated thoroughly in non-specific treatments. 97% of those in non-specific treatments did not integrate and retained their MPD.

If we now compare these percentages to the figures in my 1984b paper, we find that in that series, of 123 MPD patients whose treatments were monitored, 20 patients were still in active intense treatment at the time the study ended, and their outcome remained to be established. Ten treatments were considered failures, 10 were interrupted, and 103 reached completion or ended. In 83 or (81%) of the completed treatments the patients reached integration by research criteria. The follow-up component demonstrated that only 6% had relapsed into behavioral MPD, and that only 26% in all continued to use dissociative defenses; i.e., about one patient in twenty relapsed into a diagnosable dissociative disorder, and about one patient in four continued to use occasional dissociative coping, or had been found to have ego state phenomena without behavioral expression. Unpublished results indicate that those who relapsed fully had a poor long-term prognosis, while all of the others were able to work through their residual MPD-like coping styles in an additional spell of therapy.

Although it would be appropriate to argue that many factors make this an atypical series (e.g., the unusual degree

of experience of the prime therapist, who had successfully integrated many MPD patients before beginning the series, and most of the study having been done when there were so few people treating MPD that the patients were very eager to cooperate and very protective of the therapists involved, etc.), it nonetheless demonstrates the superiority of specific treatment to non-specific treatment and to non-treatment.

Integration Versus Resolution

Like many therapists, I encounter patients who are not interested in pursuing integration, and prefer to work toward a more harmonious relationship among the alters. I have discussed the resistance and reluctance to approach integration at length elsewhere (Kluft, 1993c). Follow-up data indicates that only a small percentage of patients with stable integration elect to abandon it. Of the patients who have done so to date, only one or two chose to do so because they preferred dissociated life. Of patients who worked for a resolution, however, over 70% returned to work for integration. That is why there is no separate resolution category in my research — most of the patients found that "functional MPD" was a myth for them and wound up in the integration group. Under pressure, most had experienced a return of dysfunctional dividedness, and/or had found that by maintaining dissociative boundaries they were prone to revictimization (a problem discussed at length elsewhere [Kluft, 1990]). They found that living with dissociation continued to confront them with the perils of what I have called "multiple reality disorder." Using different patterns of perception and thought, drawing information from different data bases, and oblivious to the contradictory nature of many of the precepts they were accepting simultaneously, they kept making errors that predisposed them to further harm, self-defeat, and unnecessary mishaps.

On the basis of this experience, I think that although it may be possible to live as a "well MPD," this is an outcome that cannot be endorsed for a patient without explaining the associated risks and obtaining informed consent. Naturally, when confronted with an MPD patient so overwhelmed that the difficult therapy necessary to affect fusion would be contraindicated, ego strengthening and working for a more harmonious alignment of the alters is the most humane and reasonable course, with the hope of pursuing integration at some later date.

The Prognosis of MPD

With the exception of an early article by the late David Caul (1988), the study of the prognosis of MPD patients has been largely a matter of experts sharing anecdotal impressions with one another. Putnam (1986) studied Kluft's 1984 data and found that complexity affected length of treatment for patients with 18 alters or less—one could predict about 3 months of therapy per alter. At higher degrees of complexity this ratio did not hold.

The figures cited above from my own research would indicate an optimistic prognosis for MPD. However, the average clinician rapidly becomes aware that they do not describe the modal encounter of the modal MPD patient with the average MPD-sensitized psychotherapist. In another outcome study, Coons (1986) followed 20 MPD patients for an average of 39 months. 67% were considered greatly improved, and 25% had integrated completely and maintained their integration. This would suggest that MPD has a favorable, but only a moderately favorable prognosis. It might appear impossible to reconcile these findings at first glance.

However, in fact, these studies are not readily comparable. and neither can be considered either typical or definitive. Dr. Coons' patients were from a state hospital setting. Their average education was less than the completion of high school. They were treated by 20 therapists, many of whom were trainees, and all but one of whom was treating his/her first case of MPD. Most saw their patients once a week, below the recommended minimal frequency, which is twice a week (Wilbur & Kluft, 1989).

In contrast, almost all of my series' patients were from the private sector. Almost all were high school graduates and many had college or graduate degrees. My series was begun after I had successfully integrated 20 MPD patients; the other clinicians were experienced (e.g., Cornelia B. Wilbur, M.D., was contributing cases). The average intensity of treatment was twice a week. These factors explain much of the difference.

However, there is another problem as well. My series included a number of patients who did not improve rapidly, and therefore were not part of the integration cohort that was the primary focus of the research. If we look at the whole spectrum of my series, it becomes clear that it includes a good many patients that do very well rapidly, and a smaller percent that do not. In fact, one could make a speculative case that there are at least two types of MPD patients, one of which integrates rapidly, and one of which does not, and that while about 75% of my series consists of the rapidly integrating patients, only about 25% of Dr. Coons' patients is this type. Conversely, about 75% of Dr. Coons' series consists of patients whose response to treatment is less positive, while this type of patient constitutes only 25% of my series.

I now will offer a preliminary report on some research in progress that strongly suggests that this is the case. I have developed a 12 item instrument designed to indicate the MPD patient's baseline level of function in a number of crucial dimensions, and then to follow the patient's function across time at regular intervals. Progress as measured by this instrument, which will be published soon (Kluft, in press), was charted for 33 MPD patients already in treatment, and for a group of 10 MPD patients newly taken into treatment. Interestingly, the established patients showed great heterogeneity in their ratings, with some improving, some remaining fixed, some declining, and some fluctuating up and down. However, of the new patients, seven made rapid gains in their ratings, and in their clinical improvement. Two made moderate gains, and showed some fluctuations. One showed minimal gains, and fluctuated widely.

A retrospective review of the other patients in the year cohorts in which the established patients had entered therapy demonstrated that excepting those with three years of treatment or less, most of the other patients in the relevant

year cohorts had already terminated intensive treatment successfully. They were integrated and seen infrequently in follow-up.

Further study of the instrument and the scores demonstrated that what was being measured was not a "honeymoon effect;" nor was a higher score easier to obtain if one started at a lower level, as one would expect for new patients. Instead, it appears that some patients rapidly embrace the therapy situation and progress very rapidly, while others, usually protesting how hard they are working, do not. I hypothesize that the patients in my study who integrated rapidly were more like the fast-responders, or High Trajectory Patients, which I infer were less highly represented in a less educated state hospital clinic population than in a small number of private practices. Since the slower-responding or Low Trajectory Patients do not improve as rapidly, one might speculate that a person with a private sector practice specializing in DDs would gradually accumulate such patients until they came to dominate his or her practice. This indeed was the case in the practice studied in the treatment trajectory study. Of the 33 established cases, about 25 were responding much more slowly than the other MPD patients who had entered treatment in the same year as themselves, while the other eight were in their second to fourth years of therapy.

Interestingly, in the year after the study concluded, at a two-year level seven of the 10 new patients (all of whom had been High Trajectory from the first) maintained or improved on their trajectories modestly. The patient who was at the lowest level skyrocketed ahead into a High Trajectory pattern and made many dramatic improvement in her life and in her intrapsychic function. One of the moderate group remained on a slow and fluctuating pattern of improvement. The second in the moderate group struggled through the second year without improving her rating, and began to deteriorate severely in the third year. At this time I think that we are on the verge of demonstrating MPD to be a very heterogeneous condition, and will soon be able to distinguish a few subtypes of MPD and further study their prognostic implications. Although these results are too crude and preliminary to be definitive, they offer the hope that in the future it may be possible to determine the prognosis and treatment course of the majority of MPD patients during a trial of therapy.

The Cost-Effectiveness of MPD Treatment

In an era in which financial concerns often threaten to crowd therapeutic advances from the mental health professions' field of vision, it is instructive to observe that a number of studies of seriously ill MPD patients has demonstrated that although their treatment is expensive, specific MPD treatment ultimately leads to a reduction in overall expenditures. Ross and Dua (1993) projected a savings of $84, 899.44 (Canadian) per patient for the application of specific treatment over the first 10 years after the making of the diagnosis. Quimby, Andrei, and Putnam (1983) studied the financial aspects of the treatment of one MPD patient who had been institutionalized chronically under a mistaken diag-

nosis, and was rehabilitated and discharged. They showed that while therapy costs increased after the diagnosis, special nursing charges were massively reduced. After discharge, but while still receiving specific therapy, the weekly costs for her treatment were only 6-21% of her baseline cost to the taxpayer. Rivera (1991) followed 185 MPD patients' involvement in the overall healthcare delivery system of Canada, and concluded that although specific treatment was expensive, it was cost-effective and brought about savings by reducing the overall demand for services necessitated by the complications of the MPD. All in all, it seems that the initial high level of expenditure necessary to bring specific treatment to MPD patients is more than compensated for by long-term savings. The data available to date indicate that the specific treatment of MPD is both clinically effective and cost-effective for most MPD patients.

Pragmatic Empirical Ground Rules for the Treatment of MPD

Because the treatment of MPD is a relatively new field, it may appear presumptuous for anyone to offer a list of rules about how to conduct the psychotherapy. Many therapists are instantly offended when they are told that there is a right way to do things; they may feel that their creativity, their unique perspectives, and/or their special talents are not being taken into consideration. Therefore I will explain how these rules were derived, and the reader can come to his or her own conclusions about their merit.

I have now consulted to approximately 1,200 therapists about the psychotherapies of roughly 1,600 MPD patients. Each time I did a consult, I wrote down what, if anything, was going wrong in the therapy. When I had the notes from 1,000 consultations, I tabulated them and reformulated every type of error and mistake into rules that were meant to help therapists avoid that type of mishap. In my next 100 consultations I tried to see how many of these rules could be broken without impeding the recovery of the patient. Much to my surprise, I found that if a therapist bent even one of these rules strongly, the patient was unlikely to do well. If the patient was improving, it was at a much slower rate than was possible, because a certain degree of impasse and blockage was being built into their therapy.

It is on the basis of this experience, and furthermore, because I learned that most of the treatments had improved when the rules were applied firmly, that I feel comfortable in sharing them. These rules were first published in 1991 (b), and the version in which they were presented at the Amsterdam conference was discussed at length in *Clinical Perspectives on Multiple Personality Disorder* (1993b).

1) *Maintain a Secure Frame and Firm Boundaries.* MPD is a condition that was created by broken boundaries. In western society, most MPD occurs in connection with intrafamilial violence and abuse, as a consequence of actions that break our laws and violate our mores. *Therefore, a successful treatment will have a secure treatment frame and firm, consistent boundaries.* Because the patient was hurt by others' breaking the rules of how families and societies should con-

94

duct themselves, the scrupulous observation of the appropriate boundaries of therapy is essential. The treatment frame must be firm and consistent. Confidentiality must be preserved. Double relationships with patients must be avoided. Every time you, the therapist, do anything but therapy with the patient you take the risk that something other than what is therapeutic will occur in the treatment.

2) *Focus on Achieving Mastery.* MPD is a condition of subjective and at time objective dyscontrol. Unwanted and unwelcome experiences were imposed upon a youngster who had no choice but to endure them. The MPD patient may have little sense of mastery, or of an internal locus of control. *Therefore there has to be a focus on mastery and the patient's active participation in the treatment process.* It is important to get the patient to do things, to take steps to be an active partner in the therapy. "Therapy must be done with the patient rather than to the patient"(Kluft, 1993b, p.28). Tasks, assignments activities—these all can be useful. If the patient is not held accountable for what is asked, there is considerable risk of encouraging a regressive dependency in which the patient looks to the therapist to supply whatever is perceived as needed, and the therapist may feel constrained to supply it.

3) *Establish and Maintain a Strong Therapeutic Alliance.* MPD is a condition of perceived and genuine involuntariness. Its sufferers did not choose to be traumatized, and they find their symptoms are often beyond their control. *Therefore, the therapy must be based on a strong therapeutic alliance, and efforts to establish this must be undertaken throughout the entire treatment process.* Even if the last ten sessions have been productive, the first concern I have with a patient is whether the patient and I are understanding one another. Are we engaged in doing what we need to do and addressing what we need to address? If we are not, that is the first problem with which I must deal.

It is a common error among those without a strong psychoanalytic background to mistake an apparent positive transference for a good therapeutic alliance. Patients' acting positively toward you may mean that they have positive feelings toward you. However, this may be a reaction formation against their hostile feelings, or a submissive compliance because they see you colored by their experience with an abuser toward whom they had to demonstrate affection. The presence of a strong therapeutic alliance means that the patient and you are doing the work of the therapy in a regular manner and there is some hope that the treatment will progress on that basis. It is crucial to cultivate a joint commitment to the work of the therapy.

4) *Deal with Buried Traumata and Affect.* MPD is a con-

dition of buried traumata and sequestered affect. *Therefore, what has been hidden away must be uncovered, and what feeling has been buried must be abreacted. it is occasionally possible to achieve a salubrious reconfiguration of the alters without dealing with the past and to direct the therapy to the smoother functioning of the alters, but integration cannot be achieved without dealing with the impact of the past.* The sense that the past has been dealt with and mastered is an essential aspect of the patient's recovery.

5) *Reduce Separateness and Conflict Among Alters. MPD is a condition of perceived separateness and conflict among the alters. Therefore, therapy must emphasize their collaboration, cooperation, empathy, and identification with one another so that their separateness becomes redundant and their conflicts muted.* It is essential to make it clear that all of the alters are "in it together," that no one alter can win, and that the most effective strategy is to find a way for all to win together.

6) *Work to Achieve Congruence of Perception.* MPD is a condition of autohypnotic alternative realities; i.e., multiple reality disorder. When a patient recounts a memory of an event, you may not be able to be confident that it is historically accurate. You only know that it is a signal, a semiotic device that says "something bad happened to me. I am in a posttraumatic state." We know all too well that memory is a very complex and tricky area of study. The therapist must be prepared to validate the patient's distress, but cannot allow himself to be put in the position of being obliged to validate everything that the patient says. All too often, what the patient says in one personality is different from the account given by another alter .

My favorite example of this was described by Loewenstein (1991b), who had been persuaded to prescribe the antidepressant imipramine for an MPD patient:

> At this point, the host personality reported triumphantly that her depressive symptoms had abated without a single side effect. Just after this, the patient switched and a second alter emerged. This alter commented acidly that she discerned absolutely no positive or negative effect from the new medication and questioned why she was taking it. Suddenly, a third switch revealed a mournful looking alter with tremulous hands who reported tremor, dry mouth, constipation, dizziness on standing, palpitations, and several other side effects since beginning the medication. She denied any benefit from the medication. Finally, another quick switch produced an adolescent alter who whispered conspiratorially, "Please don't tell them. Whenever she puts a pill up to her mouth to take it, I take it away

and save it in my stash for my overdose." This patient had not taken a single dose of the prescribed medication. (Loewenstein, 1991b, p. 727)

Now, let us suppose that the first alter had said, "My uncle raped me." Furthermore, suppose a second said, "My father raped me." Perhaps a third personality might say, "My father and uncle are the most wonderful people in the world." Yet another might say, "I was born into a different family, and I don't even know those people and who they are talking about." As the therapist you are often dealing with problematic alternate realities. Never hesitate to confront the patient, not in the manner of an interrogator or detective, but in a gentle way. You may ask about alternative explanations or statements that you have heard, and invite participation in a mutual exploratory process rather than accord premature veracity to one version or another.

Closely linked with this is the need to communicate quickly, tersely, and nicely. *Therefore, the therapist's communications must be clear and straight. There is no room for confusing communications.* If you make long and complex interventions, MPD patients may switch in the middle of your interpretation if they are upset by what you are saying. For all practical purposes, they will never hear it. Yet as you talk they will nod their heads "yes" because they know they are supposed to, and, like many abused children, they will comply with the implicit demands of the (potentially dangerous) authority figure.

You will want to be terse, quick, and on target. If you figure out an interpretation or intervention that combines the past, present, future, transference, reality, and everything you could want to include— if as this interpretation or intervention formulates itself in your mind, you know that this should go directly from your lips to the pages of a book entitled "What Really Great Therapists Say to their Really Lucky Patients"—go home and tell it to your mother. She is probably the only person on the face of the earth who is not yet disillusioned with your narcissism.

Certainly, the MPD patient does not need this sort of thing from you. MPD patients need short bits of insight that they can metabolize without blowing them out of proportion or experiencing some form of mental indigestion.

7) *Treat All Personalities Evenhandedly and with Consistency.* MPD is a condition related to the inconsistency of important others. *Therefore, the therapist must be evenhanded to all of the alters and must avoid "playing favorites" or dramatically altering his or her own behavior toward the different personalities. The therapist's consistency across all of the different alters is one of the most powerful assaults on the patient's dissociative defenses.* If an MPD patient

has a therapist who will change in response to which alter is out, he or she now has multiple therapist disorder. It is more helpful if the patient who switches in order to get away from what the therapist is saying finds the therapist very much the same. This allows the therapist to "bore the patient into health" instead of becoming involved in a process that is parallel to the patient's psychopathology. I frequently am consulted by therapists who have spent years playing with child alters, without the treatment's having been advanced.

8) *Restore Shattered Basic Assumptions.* The shattering of the basic assumptions described by Janoff-Bulman (1985), that one is relatively invulnerable, that life is meaningful, and that one can see oneself in a positive light, is profoundly demoralizing. It is not uncommon for these patients to be sure that some situation or some finding in therapy will be too much for them to manage, so they might as well hurt or destroy themselves, or yield to persons who want them to do something that is not in the patient's best interests. They often feel impotent. MPD patients generally feel very badly about themselves, and cannot be reassured by being told that they are good or not at fault. Their usual response to such efforts is to perceive the therapist as uncomprehending (of their true badness) or as having ulterior motives (because in their experience, kind words have often been the prelude to exploitation or harm). *Therefore, the therapy must make positive efforts to restore morale and to inculcate realistic hopes.* Perhaps you will recall that I advocated activating the patient, giving the patient things to do, and following up all assignments, even if the assignment was to think about something. The way I have found MPD patients can accept reassurance and gradually rebuilt shattered assumptions is when they can be reminded of what they thought they could not accomplish, but in fact were able to do. I point out that despite the patient's genuine conviction that he or she is powerless, together we have seen many situations in which that belief proved erroneous. On the basis of past experience, I maintain that the patient will be able to work with me to handle the current challenges, in the face of his or her belief that this is impossible and beyond his or her capacities.

9) *Minimize Avoidable Overwhelming Experiences.* MPD is a condition stemming from overwhelming experiences. *Therefore, it is essential to pace the therapy.* It is important to prevent the patient's being given more pain by the therapy than can be tolerated, with consequent decompensation. When in doubt as to whether the patient can handle a particular observation or information at a given point of treatment, it is better to withhold than to risk imposing potentially devastating pain. It is useful to apply an axiom

96

that has been linked with my name, "Kluft's rule of thirds." If you know you and the patient are planning to deal with difficult material in a session, but you cannot get into this material in the first third of the session so that you can work on it in the remainder of the first third and the second third, reserving the last third to process the material and restabilize the patient, do not proceed with the exploration of the material. It is more productive to explore the resistance that has caused the patient to delay getting into the material, or, if pressed to begin exploration too late in the session, to probe the masochistic dynamics that cause the patient to think that he or she should be exposed to potentially painful and disruptive material without sufficient time to manage it in a safe and thoughtful manner.

10) *Model, Teach, and Reinforce Responsibility.* MPD is a condition that often results from the irresponsibility of important others. Therefore, the therapist must be very responsible and must hold the patient to a high standard of responsibility once the therapist is confident that the patient, across alters, actually understands what reasonable responsibility entails. Bear in mind that MPD patients may not appreciate what responsibility means. Their consciences or superegos are not normal in some respects. They usually have been exposed to two standards: that they were always wrong and that someone else was always right, no matter what the circumstances. They also often have lacunae (holes) in their moral reasoning, because they are very phobic of certain memories, affects, etc. They usually have a set of internal rules that allow them to escape from particular feared situations and obligations. It may take months to deal with this. The therapist begins by being firm, but knowing the patient may not be able to comply. *The therapist must be very responsible and must hold the patient to a high standard of responsibility once the therapist is confident that the patient, across alters, actually understands what reasonable responsibility entails.* This usually results from discussion of the patient's response to the assignments and tasks given in the therapy.

11) *Take an Active, Warm, and Flexible Therapeutic Stance.* MPD often results in part because people who could have taken action to protect a child did nothing. *The therapist can anticipate that passivity, affective blandness, and technical neutrality will be experienced as uncaring and rejecting behavior, and that the therapy is better served by taking a warm and active stance that allows a latitude of affective expression.* There are several compelling reasons for this advice. The first is that such a stance is much more effective with trauma victims, who often perceive relative remoteness in the therapist as a distancing of the therapist from them and their shameful circumstances. The second is that in

an interpersonal field that may become dominated by traumatic transferences, the therapist may be seen as a dangerous and hurtful person. If the therapist has not been relatively real, the patient may have more than the usual amount of difficulty seeing the therapist through his or her projections, and the patient may, in the grips of powerful emotions, be unable to distinguish past and present and behave toward the therapist as if he or she were an enemy the patient has to attack in order to be safe.

There is a third reason why I think it is important to be warm and to have shown a wide spectrum of affect expression in the therapy. I am not advocating extreme reactivity or "acting out," only the demonstration of a series of natural responses within a mild range. You will make countertransference errors with these patients very frequently. If you treat many, it will be a daily experience. The pressure and the complexity of the transferential field and the projective identifications can be extreme. Coons (1986) has tabulated the types of countertransferential responses therapists have to MPD patients, and Loewenstein (1993) has studied them in depth. Suffice it to say that since you will make errors, minor and major, with some degree of frequency, the only way to recover them is your having a reasonably wide range of responses to the patient already in your shared history as a therapeutic dyad.

If the therapist is affectively bland, and suddenly starts screaming at the patient, the enormity of the change may rupture the therapeutic alliance and the good feeling that may exist between the two of you. Conversely (and here we must recall that perception relates to change from a baseline, not to an absolute scale of things), a therapist with a wider range of baseline expression will be perceived to be "even worse than usual." I recall a patient's remarking after I had made an error, "Boy, you are even crankier than usual today!" In that context, it is rare that an error will have the potential to destroy the therapy.

I believe that the wider affective stance is good insurance for the patient's investment in the therapy. I am prepared to hear the objection that this rule simply covers over the ineptitude and poor control of the therapist, and may be designed to rationalize my flaws of character. However, the treatment of MPD can be incredibly intense work. I have never met a therapist who treats MPD patients on a regular basis who does not find himself or herself in situations like this fairly frequently.

12) *Address and Correct Cognitive Errors.* MPD patients usually have developed many cognitive errors (Fine, 1988a, 1990). It becomes crucial to explore how the MPD patient thinks, and address the thinking problems in therapy. *The therapy must address them and correct these cognitive errors on an ongoing basis.* You do

97

not need to do formal cognitive therapy, but you must be aware that if you say, "ABC, Julia," to an MPD patient, and she smiles and says, "ABC, Dr. Kluft," you may not have shared a mutual understanding. Julia's "ABC" response may have been the product of an inner process something like this: "Hey, the jerk is asking you a question, give him the answer so he'll leave us alone." "I don't understand what the answer is. somebody tell me." "Say A." (Aloud, the patient says "A.") "I don't believe B" "I don't believe it either." "Kluft is really going to be angry if we don't say 'B.'" "I don't want to say 'B.'" "Sally will get scared if Dr. Kluft gets angry." "I'm not afraid of him." "Sally and the other kids will cry all week if they think he is angry, and then they won't let us go to session and then he'll really be angry." "OK already, say whatever you want." (Aloud, the patient says "B.") A similar process goes on for "C." The emitted "ABC" would seem to indicate a complete mutual communication, when in fact the patient has verbalized what was expected in response to a dysfunctional chorus of inner voices, and has felt confused and on the verge of psychosis throughout the process. It is imperative to sensitize yourself to the presence of compliant agreement used as a defense against being touched by the process of the therapy, or of masking total incomprehension.

The Crucial Role of the First Two Phases of Treatment

MPD patients are often very vulnerable people, and the treatment of MPD is very demanding. The therapy asks a lot from an already beleaguered and traumatized person. It is useful to engage in some unscientific calculations, which I call "the mathematics of misery." These figures should be regarded as a speculation, and not cited as anything more. We all would agree that a single serious sexual assault is odious and constitutes an egregious traumatization. No one would trivialize a rape, and recovery for a rape may require considerable treatment over a protracted period of time. If we make the estimate that the average MPD patient is misused twice a week, perhaps 50 weeks of the year, and use the statistic from Schultz, Braun, and Kluft's 1989 study of 355 MPD patients, that the average MPD patient reports having been abused an average of ten years, then an average or modal MPD patient may have endured 2 X 50 x 10 = 1,000 exploitations.

We appreciate how difficult it is for the victim of a single rape to undergo an affectively-charged review of his or her experiences, even if he or she had functioned well before. How much more difficult it must be for a victim of a hundred or a thousand-fold more abuses, whose prior level of function may have been compromised, or, if apparently normal, achieved at the cost of all her concentration and effort.

Therefore, it is important to begin therapy not by addressing the painful and traumatic material, but instead to building up the patient's ego strength adaptive capacities, and supports. I do not know any competent mental

health professional who works with MPD on a regular basi who approaches trauma early in therapy except to contai irruptions of the material as best they can. Unfortunately, frequently encounter neophytes who pursue this practic and who have come to believe that a period of decompe sation is an inevitable concomitant of beginning the ther py. The subject of strengthening the patient for treatmen was the focus of another communication at the Amsterda conference, to which the reader is referred (Kluft, 1993b)

Hypnosis

Because the subject of the use of hypnosis in MPD is th subject of many articles, including two recent reviews (Kluf 1992a, 1992b), I will not dwell upon it at length here. It i clear that hypnosis has many important roles to pay in th treatment of MPD, especially in the service of facilitating st bilization, strengthening, and integration. It is also clear tha any use of hypnosis to retrieve memories is fraught with th same concerns and constraints that attend such procedure with any group of patients and under any circumstances.

Furthermore, it is clear that due to the high hypnoti ability of this group of patients, and the ubiquity of spont neous trance and autohypnotic episodes among them, th omission of efforts to induce formal heterohypnosis is n assurance that an hypnotic ambiance will not pervade th entire treatment. Therefore, the therapist who works wit this patient group is well-advised to study hypnosis throug an appropriate series of courses under the aegis of or cospon sored by a recognized hypnosis society, medical school, o department of psychology.

Integration

At this point in time it has been established that MP patients can achieve and sustain a full integration (Kluf 1984b, 1986). However, our understanding of the proces remains metaphoric at best. Integration is a puzzling even when it occurs. I remain confused and disconcerted by th fact that I can work with a "personality" over a period o years, only to find that it has ceased to be separate, eithe spontaneously, through some mediated process, or via a integration ritual. I have addressed this subject at length elsewhere (Kluft, 1993c).

Desiderata

As we look to the future, I am acutely aware of the nee for more research about the psychotherapy of MPD. To dat most research in the field has focused on phenomenolgy psychophysiology, and epidemiology. We can describe an discover MPD with increasing efficiency, but our treatmen remains informed by the experiences and advices of a smal group of pioneers.

At this moment, we cannot be sure whether our curren approaches to the treatment of MPD are approaching a defini tive stage, or are quite primitive with regard to the forms they will take in the future. I would like to see the develop ment of valid and reliable instruments and protocols tha will facilitate the carrying out of multitherapist and multi center studies on the treatment of MPD. I also would like t

see research analyzing the work of those therapists who are recognized as most expert and effective. Clearly, some effective therapists are doing things that others are not, and what those therapists say they are doing may not correspond to their actual behaviors (Bennett G. Braun, M.D., personal communication, May, 1979, cited in Kluft, 1984b). If these differences bear on efficacy, they should be studied and explained in a manner that will allow other therapists to use them to enhance their work.

I am deeply saddened that the therapeutic techniques of the late Cornelia B. Wilbur, M.D., were never studied systematically. We cannot reconstruct them from the observations of those who consulted her, because her style was to encourage and enhance the skills and approaches of her consultees, rather than to teach them to do things her way. As useful as Schreiber's (1973) *Sybil* may be, it is a lay source, with contents selected for reasons other than their clinical importance, which depicts Dr. Wilbur as she was learning to treat MPD, and does not illustrate her interventions when she was at the peak of her power. Many times Dr. Wilbur told me that if she had to treat Sybil with the expertise she had acquired by the 1980s, she would have needed four rather than 11 years to complete her therapy. There is no known record of Dr. Wilbur at work during the years that she felt she was most effective.

We need to study the effect of contemporary culture and psychoeducational measures upon the manifestations and clinical course of MPD. Although I am aware that some will be offended by this observation, it is clear to me that my MPD patients in the 1970's, as a group, simply worked in therapy, got well, and went on about their lives. As we have learned more about the condition, and as MPD patients educate themselves about their disorder (at times with greater dedication and assiduity than their therapists), report themselves triggered by discussions of MPD and child abuse on television talk shows, and beg to be referred to support groups, I see a sizable percentage of the MPD patients of the 1990s as behaving differently in many ways from the patients I began to work with in the 1970s. Most of those newer ways seem to be associated with a longer and more stormy clinical course. Something is happening, and it requires objective and undefensive study.

Much as we need to learn as much as we can about treating MPD, we also need to know what constitutes adequate care as opposed to ideal care on the one hand and inadequate care on the other. We also need to learn what level of care a given MPD patient needs (rather than wants). I am shocked and chagrined by efforts to prescribe insufficient and inadequate care to MPD patients in the name of cost-containment. Likewise, I am disconcerted and upset with the pleas and imperious demands by some MPD patients for an extremely intense and expensive level of treatment, and an insistence that anything less constitutes abuse. Absent objective data, we and our patients may become the victims of economic politics.

A final area of research I consider urgent is the study of the protection and well-being of the therapist who works with MPD and other traumatized subgroups. There is an inherent risk of burn-out and secondary posttraumatic stress among therapists who work with considerable numbers of trauma patients. While some of us have managed to deal with this quite nicely, others have not. I have no idea of why this is so, nor have I been able to find any factors that distinguish those who experience from those who avoid such consequences. However, as more and more MPD patients are recognized and more and more therapists are becoming involved in their care, the need to look to the welfare of our colleagues and ourselves becomes all the more compelling. ∎

REFERENCES

Adityanjee, Raju, J.S.P., & Khandelwal, S.K. (1989). Current status of multiple personality disorder in India. *American Journal of Psychiatry*, 147, 1260-1261.

Allison, R.B. (1974). A new treatment approach for multiple personalities. *American Journal of Clinical Hypnosis*, 17, 15-32.

Bandura, (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84, 191-215.

Bliss, E.L. (1986). *Multiple personality, allied disorders, and hypnosis.* New York: Oxford.

Boon, S., & Draijer, N. (1993). *Multiple personality disorder in the Netherlands.* Amsterdam: Swets & Zeitlinger.

Bowers, M.K., Brecher-Marer, S., Newton, B.W., Piotrowski, Z., Spyer, T.C., Taylor, W.S., & Watkins, J.G. (1971). Therapy of multiple personality. *International Journal of Clinical and Experimental Hypnosis*, 19, 57-65.

Braun, B.G. (Ed.). (1984). Symposium on multiple personality. *Psychiatric Clinics of North America*, 7,1.

Braun, B.G. (1986) *Treatment of multiple personality disorder.* Washington, DC: American Psychiatric Press.

Caul, D. (1988). Determining prognosis in the treatment of multiple personality disorder. *DISSOCIATION*, 1(2), 24-26.

Coons, P.M. (1986). Treatment progress in 20 patients with multiple personality disorder. *Journal of Nervous and Mental Disease*, 174, 715-721.

Crabtree, A. (1993). Multiple personality before "Eve." *DISSOCIATION*, 6(1), 66-73.

Despine, A. (1840). *De l'emploi du magnetisme animal et des eaux minerales dans le traitment des maladies nerveuses, suivi d'une observation tres curieuse de guerison de nevropathie.* Paris: Germer, Balliere.

Ellenberger, H. (1970). *The discovery of the unconscious.* New York: Basic Books.

Fine, C.G. (1988a). Thoughts on the cognitive perceptual substrates of multiple personality disorder. *DISSOCIATION*, 1(4), 5-10.

99

Fine, C.G. (1988b). The work of Antoine Despine: The first scientific report on the diagnosis and treatment of a child with multiple personality disorder. *American Journal of Clinical Hypnosis*, 31, 32-39.

Fine, C.G. (1990). The cognitive sequelae of incest. In R.P. Kluft (Ed.), *Incest-related syndromes of adult psychopathology* (pp.161-182). Washington, DC: American Psychiatric Press.

Fine, C.G. (1991). Treatment stabilization and crisis prevention: Pacing the therapy of the multiple personality disorder patient. *Psychiatric Clinics of North America*, 14, 661-676.

Fine, C.G. (1993). A tactical integrationalist perspective on the treatment of multiple personality disorder. In R.P. Kluft & C.G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 135-154). Washington, DC: American Psychiatric Press.

Greaves, G.B. (1993). A history of multiple personalty disorder. In R.P. Kluft & C.G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 355-380). Washington, DC: American Psychiatric Press.

Herman, J.L. (1992). *Trauma and recovery.* New York: Basic Books.

Janoff-Bulman, R. (1985). The aftermath of victimization: Rebuilding shattered assumptions. In C.R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (pp. 15-25). New York: Brunner/Mazel.

Kluft, R.P. (1984a). Multiple personality in childhood. *Psychiatric Clinics of North America*, 7, 121-134.

Kluft, R.P. (1984b). Treatment of multiple personality disorder. *Psychiatric Clinics of North America*, 7, 9-29

Kluft, R.P. (1985). The natural history of multiple personality disorder. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp.197-238). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1986). Treating children who have multiple personality disorder. In B.G. Braun (ed.), *Treatment of multiple personality disorder* (pp. 79-105). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1988a). The postunification treatment of multiple personality disorder: First findings. *American Journal of Psychotherapy*, 42, 212-228.

Kluft, R.P. (1988b). Editorial: Today's therapeutic pluralism. *DISSOCIATION*, 1(4), 1-2.

Kluft, R.P. (1990). Dissociation and subsequent vulnerability: A preliminary study. *DISSOCIATION*, 3(2), 167-173.

Kluft, R.P. (1991a). Clinical presentations of multiple personality disorder. *Psychiatric Clinics of North America*, 14, 605-630.

Kluft, R.P. (1991b). Multiple personality disorder. In A. Tasman & S.M. Goldfinger (Eds.), *The American psychiatric press annual review of psychiatry* (vol. 10) (pp. 161-188). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1992a). Hypnosis with multiple personality disorder. *American Journal of Preventive Psychiatry & Neurology*, 3, 19-27.

Kluft, R.P. (1992b). The use of hypnosis with dissociative disorders. *Psychiatric Medicine*, 10, 31-46.

Kluft, R.P. (1993a). The initial stages of psychotherapy in the treatment of multiple personality disorder patients. *DISSOCIATION*, 6 (2-3), 145-161.

Kluft, R.P. (1993b). Basic principles in conducting the psychotherapy of multiple personality disorder. In R.P. Kluft & C.G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 19-50). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1993c). Clinical approaches to the integration of personalities. In R.P. Kluft & C.G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 101-133). Washington, DC: American Psychiatric Press.

Kluft, R.P. (in press). Treatment trajectories in the psychotherapy of multiple personality disorder. *DISSOCIATION.*

R.P. Kluft & C.G. Fine (Eds.) (1993). *Clinical perspectives on multiple personality disorder*. Washington, DC: American Psychiatric Press.

Kohut, H. (1977). *The restoration of the self.* New York: Interntional Universities Press.

Loewenstein, R.J. (Ed.). (1991a). Multiple personality disorder. *Psychiatric Clinics of North America*, 14, 3.

Loewnstein, R.J. (1991b). Rational psychopharmacology in the treatment of multiple personality disorder. *Psychiatric Clinics of North America*, 14, 721-740.

Loewenstein, R.J. (1993). Posttraumatic and dissociative aspects of transference and countertransference in the treatment of multiple personality disorder. In R.P. Kluft & C.G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 51-86). Washington, DC: American Psychiatric Press.

Nathanson, D.L. (1992). *Shame and pride: Affect, sex, and the birth of the self.* New York: Norton.

Putnam, F.W. (1986). The treatment of multiple personality: State of the art. In B.G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 175-198.

Putnam, F.W. (1989). The diagnosis and treatment of multiple personality disorder. New York: Guilford.

Putnam, F.W. (1993). Diagnosis and clinical phenomenology of multiple personality disorder: A North American perspective. *DISSOCIATION*, 6(2-3), 80-86.

Quimby, L.G., Andrei, A., & Putnam, F.W. (1993). Deinstitutionalization of patients with chronic multiple personality disorder. In R.P. Kluft & C.G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 201-225). Washington, DC: American Psychiatric Press.

Rivera, M. (1991). Multiple personality and the social systems: 185 cases. *DISSOCIATION*, 4(2), 79-83.

Ross, C.A. (1989). *Multiple personality disorder: Diagnosis, clinical features and treatment.* New York: Wiley.

Ross, C.A., & Dua, V. (1993). Psychiatric health care costs of multiple personality disorder. *American Journal of Psychotherapy*, 47, 103-112.

Schreiber, F.R. (1973). *Sybil.* Chicago: Henry Regnery.

Schultz, R., Braun, B.G., & Kluft, R.P. (1989). Multiple personality disorder: Phenomenology of selected variables in comparison to major depression. *DISSOCIATION*, 2(1), 45-51.

Sizemore, C., & Pittillo, E. (1977). *I'm Eve.* Garden City, NY: Doubleday & Co.

Steinberg, M. (1993). *Structured clinical interview for DSM-IV dissociative disorders (SCID-D).* Washington, DC: American Psychiatric Press.

Thigpen, C.H., & Cleckley, H.M. (1954). A case of multiple personality. *Journal of Abnormal and Social Psychology*, 49, 135-151.

Thigpen, C.H, & Cleckley, H.M. (1957). *The three faces of Eve.* New York: McGraw Hill.

Watkins, J.G., & Watkins, H.H. (1979). Theory and practice of ego state therapy: A short-term therapeutic approach. In Grayson, H. (Ed.), *Short-term approaches to psychotherapy* (pp. 176-220). New York: Human Sciences Press.

van der Hart, O., Boon, S., Steele, K., & Brown, P. (1993). The treatment of traumatic memories: Synthesis, realization and integration. *DISSOCIATION*, 6(2-3), 102-118.

van der Hart, O., Brown, P., & van der Kolk, B.A. (1989). Pierre Janet's treatment of post-traumatic stress. *Journal of Traumatic Stress*, 2, 379-395.

van der Hart, O., Brown, P., & Turco, R.N. (1990). Hypnotherapy for traumatic grief: Janetian and modern approaches. *American Journal of Clinical Hypnosis*, 32, 263-271.

van der Hart, O., Brown, P. (1992). Abreaction re-evaluated. *DISSOCIATION*, 6(2), 127-138.

van der Hart, O., & Friedman, B. (1989). A reader's guide to Pierre Janet on dissociation: A neglected heritage. *DISSOCIATION*, 2(1), 3-16.

Wilbur, C.B., & Kluft, R.P. (1989). Multiple personality disorder. In American Psychiatric Association (Ed.), *Treatments of psychiatric disorders* (vol. 3, pp.2197-2216). Washington, DC: American Psychiatric Press.

101